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IN THE

Supreme Court of the United States

CHARLES THOMAS SELL,

Petitioner,

v.

UNITED STATES OF AMERICA

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

MOTION FOR LEAVE TO FILE BRIEF FOR AMICUS CURIAE AMERICAN PSYCHOLOGICAL ASSOCIATION AND BRIEF FOR AMICUS CURIAE AMERICAN PSYCHOLOGICAL ASSOCIATION

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The American Psychological Association (APA) respectfully moves for leave to file a brief as amicus curiae in this case. Although respondent, the United States, has granted consent to the filing of this brief (and that written consent has been filed with the Clerk of this Court), petitioner has not granted such consent.

The APA is a voluntary nonprofit scientific and professional organization with more than 155,000 members and affiliates. APA has been the principal association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country. Psychologists have been involved in psychopharmacology and medication issues for many years. APA has two divisions that focus on psychopharmacology—Division 28, Psychopharmacology and Substance Abuse, and Division 55, American Society for the Advancement of Pharmacotherapy—and publishes the peer-reviewed *Journal of Experimental and Clinical Psychophar-*

macology. APA members teach in medical schools and in teaching hospitals. Clinicians who are members of APA assess and treat many individuals who face criminal prosecution, including those who have been found incompetent to stand trial. APA members therefore have substantial expertise and a professional and scientific interest in the appropriate use of antipsychotic drugs and other treatment modalities in that context. APA also has a broader ethical and professional interest in ensuring that persons with mental illness are treated in a humane and beneficial manner.

For the foregoing reasons, the motion for leave to file the brief for amicus curiae American Psychological Association should be granted.

Respectfully submitted.

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INTEREST OF AMICUS CURIAE

The American Psychological Association (APA) is a voluntary nonprofit scientific and professional organization with more than 155,000 members and affiliates.[1] APA has been the principal association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country. Psychologists have been involved in psychopharmacology and medication issues for many years. APA has two divisions that focus on psychopharmacology—Division 28, Psychopharmacology and Substance Abuse, and

[1] No counsel for a party authored any part of this brief. No person or entity other than the APA, its members, and its counsel made any monetary contribution towards the preparation or submission of this brief. The written consent of respondent United States to the filing of this brief has been filed with the Clerk of this Court. Petitioner has not provided such consent.

Division 55, American Society for the Advancement of Pharmacotherapy—and publishes the peer-reviewed *Journal of Experimental and Clinical Psychopharmacology*. APA members teach in medical schools and in teaching hospitals. Clinicians who are APA members assess and treat many individuals who face criminal prosecution, including those who have been found incompetent to stand trial. APA members therefore have substantial expertise and a professional and scientific interest in the appropriate use of antipsychotic drugs and other treatment modalities in that context. APA also has a broader ethical and professional interest in ensuring that persons with mental illness are treated in a humane and beneficial manner.[2]

SUMMARY OF ARGUMENT

This case involves a criminal defendant not yet adjudicated of any crime, who has been found incompetent to stand trial, but who has refused to accept treatment with antipsychotic medications that, the government maintains, might restore his trial competence.[3] That defendant has also been determined by the lower courts not to present a danger to himself or others. The government's only justification for administering drugs to him, therefore, is to bring him to trial. Although this case comes to the Court on the assumption that the defendant is charged only with non-violent offenses, the issues reach more broadly, and concern the decision-making process to be employed by a trial court whenever the government seeks to administer such medication to *any* nondangerous defendant who has been found incompetent to stand trial.

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[2] The APA wishes to acknowledge the assistance of Michael F. Enright, Ph.D., Solomon M. Fulero, Ph.D., J.D., Kirk Heilbrun, Ph.D., Rafael Rivas-Vasquez, Psy.D., and Morgan T. Sammons, Ph.D., in the preparation of this brief.

[3] "Antipsychotic" drugs are typically grouped under the broader rubric of "psychotropic" drugs. "Psychotropic medications can include sedatives and tranquilizers . . . , hypnotics . . . , mood stabilizers . . . , antidepressants . . . , [and] antipsychotics. . . ." David M. Siegel et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of the Criminal Defendant*, 2001 Wis. L. Rev. 307, 345.

A defendant who has been charged with, but has not been convicted of, any offense has at least three profound constitutionally protected interests at stake when the government proposes to undertake the coercive administration of antipsychotic drugs. First, the defendant has an obvious interest, protected as a matter of substantive liberty by the Due Process Clause, in the control of his own body. Second, when powerful drugs affecting brain chemistry are at issue, the defendant also has an interest protected by the First Amendment and the Due Process Clause in his own thought processes. Third, because antipsychotic drugs may affect a defendant's courtroom demeanor and ability to communicate with his attorney, forcible medication may implicate his Fifth and Sixth Amendment trial rights.

In light of the serious intrusion on those weighty interests that accompanies forcible administration of antipsychotic drugs, the trial court should first explore possibilities of less intrusive, non-drug treatment for a particular defendant, and should not order medication unless it is convinced that non-drug therapy alone would be ineffective. In doing so, the court need not force the government to put the defendant through a pointless exercise. If the court is persuaded, based on the testimony of qualified health care professionals, that a particular individual's disorder will not respond to non-drug therapy, the court should proceed to consider the appropriateness of particular medications proposed by the government.

When a trial court concludes that non-drug therapy would not be effective in restoring a particular defendant to competency, the court should not simply assume, however, that coercive administration of drugs *would* be appropriate for that defendant. Antipsychotic drugs can indeed be highly effective and in many cases are medically appropriate. On the other hand, there is a highly significant difference be-

tween the government's purpose in a case like this—coercively restoring a defendant to competence—and the usual situation in which a health-care professional treats a willing patient. Because the individual has a strong interest in avoiding unwanted medications, the trial court should order coercive administration of antipsychotic drugs only if it is persuaded that the specific medications that the government proposes to administer have a substantial likelihood of success in restoring the defendant to competence, and that that likelihood of success clearly outweighs the possible side effects.

In making the determination whether the proposed treatment would be medically appropriate, the trial court must be mindful of the particular characteristics of the defendant's specific disorder and of the medications under consideration, and specifically cannot assume that a medication that is known to be effective for one disorder will likely be effective for another. Many mental disorders that bear some resemblance to one another respond very differently to medication. A court would not be justified in ordering that a defendant with one psychotic disorder be treated with antipsychotic drugs solely because those drugs benefit patients with a different disorder.

The trial court should also carefully consider the side effects of the medication that the government proposes to use. The side effects of some antipsychotic drugs can be very serious, even severe. The advent of "atypical" or second-generation antipsychotic drugs, which are more easily tolerated by most patients and have an apparently lower risk of long-term debilitating side effects, may be pertinent to the trial court's decision, especially now that one such drug has been approved in injectable form. But while the new drugs are an important clinical advance, they are not panaceas. If there is significant disagreement among the professionals as to whether a defendant with a particular disorder will respond to particular medications, or what the side effects of particular medications will be, the court should probe more deeply.

If non-drug therapy is ruled out and drug therapy is thought likely to succeed, the court must nevertheless consider the potential for side effects and do everything it can to minimize or avoid them.

Finally, the court should consider the possibility that antipsychotic drugs may impair the defendant's fair trial rights. Many antipsychotic drugs have the effect of deadening the recipient's reactions, or making him seem restless. This appearance of boredom or restlessness can prejudice the defendant in the eyes of the jury. The drugs can also cloud the defendant's cognition and thus impair his ability to understand the case and communicate with his attorney. If, as trial approaches or at the time of trial, the court concludes that the medication is prejudicing the defendant's fair trial rights, it should decline to order trial of the defendant in his medicated state.[4]

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[4] In addition, in a criminal case involving coercive administration of antipsychotic drugs, there are potentially at least two other significant issues that are not directly presented by this case. First, additional complications may arise when the defendant has been found to be incompetent to refuse medical treatment, as well as incompetent to stand trial. In this case, however, the government has not argued that Dr. Sell is incompetent to make decisions concerning his own health care, and it must therefore be assumed that he competently and rationally decided to refuse antipsychotic drugs. *See Rivers* v. *Katz*, 495 N.E.2d 337, 342-344 (N.Y. 1986) (individuals presumed competent to make medical decisions); *Rogers* v. *Commissioner*, 458 N.E.2d 308, 312-314 (Mass. 1983) (same); Siegel et al., *supra*, at 358-360 (noting that standards for competence to stand trial and competence to make medical decisions are distinct). Although, in some cases, defendants suffering from psychotic disorders who are found incompetent to stand trial may also be found incompetent to make medical decisions, that is less likely to be true in the case of a defendant, such as Dr. Sell, who suffers from delusional disorder. Persons with delusional disorder—unlike, for example, many persons with schizophrenia—often operate a high level of functionality and are "able to maintain employment, . . . to belong to professional or social organizations, [and to] manage [their] daily affairs . . . ." J. Robert Noonan, *Competency to Stand Trial and the Paranoid Spectrum*, 17 Am. J. Forensic Psychol. 5, 11 (1999).

ARGUMENT

The critical starting point in this case is the recognition that the government's interest at issue is not broadly to restore Dr. Sell to mental health, but rather only to restore his competence to stand trial. For that reason, even if a defendant's mental illness interferes with his ability to understand and participate in the proceedings against him, it does not follow that any therapy that might be tried to treat him with his consent in a conventional mental-health setting is justified to restore him to competence. While mental health and competence obviously are related, they are not the same thing.

When, as here, the defendant is a nondangerous pretrial detainee who competently and rationally objects to antipsychotic drugs, the government does not have an undifferentiated interest in treating his mental illness. "Our legal system is premised upon a principle of autonomy for individuals, particularly in making decisions which principally affect their own lives," David M. Siegel et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of*

Second, the lower courts have reached somewhat differing conclusions on whether the decision on the appropriateness of coercive administration of antipsychotic drugs to a criminal defendant is to be made *de novo* by the trial court hearing the criminal case, or whether the courts should exercise a more deferential standard of review, akin to arbitrary and capricious review under the Administrative Procedure Act, of a decision by government health-care professionals that such administration is appropriate. *See generally* Siegel et al., *supra*, at 334-339. In this case, the district court found (contrary to the Bureau of Prisons) that Dr. Sell was *not* dangerous to himself or others, *see* Pet. App. 37-40, and then apparently exercised *de novo* review over the question whether forcible medication was appropriate solely for the purpose of restoring him to competency to stand trial, *see* Pet. App. 4 (noting that the magistrate "conducted a full judicial hearing" on the issue). The government did not argue that a more lenient standard of review was appropriate. *See* Gov't C.A. Br. 22 n.6. Accordingly, while the APA is of the view that a *de novo* judicial determination is required, the Court need not decide that question in this case.

the Criminal Defendant, 2001 Wis. L. Rev. 307, 357, and the government does not have a broad *parens patriae* power that permits it to take whatever steps are necessary (coercively, if need be) to restore someone's mental health. Thus, the question the trial court must consider is not (as a patient might consider for herself) whether a particular course of treatment *might* be effective, but rather whether the government's narrow interest in attaining competence justifies the serious intrusions involved in coercive administration of antipsychotic drugs.

A. In a Case Involving a Defendant Who Is Not Competent To Stand Trial, a Court Should First Consider Whether Any Non-Drug Therapy Could Restore The Defendant To Competence

1. Competence to stand trial is a legal standard expressed in functional terms. A defendant is competent to stand trial when he demonstrates "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding," as well as "a rational as well as factual understanding of the proceedings against him." *Dusky* v. *United States*, 362 U.S. 402, 402 (1960) (per curiam). In some circumstances, when an individual's trial incompetence is a product of mental illness, antipsychotic drugs may be effective in alleviating the symptoms of the disorder, and thereby help the defendant become competent. Antipsychotic drugs achieve these results by "alter[ing] the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes." *Washington* v. *Harper*, 494 U.S. 210, 229 (1990).

When a defendant competently and rationally refuses to accept antipsychotic drugs, however, at least three weighty, constitutionally protected interests of the individual are at stake. *First*, the individual has a right, firmly rooted in the common law and protected as a matter of substantive liberty by the Due Process Clauses of the Fifth and Fourteenth

Amendments, to "determine what shall be done with his own body." *Schloendorff* v. *Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.); *see Ingraham* v. *Wright*, 430 U.S. 651, 673 (1977) (noting that "[a]mong the historic liberties" protected at common law was the freedom against "unjustified intrusions on personal security") (quoting 1 W. Blackstone, *Commentaries* * 134)). That right is surely one of the fundamental personal rights that is "implicit in the concept of ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937) (Cardozo, J.) (internal quotation omitted). As the Court has recognized, "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Harper*, 494 U.S. at 1229; *see Riggins* v. *Nevada*, 504 U.S. 127, 134 (1992); *see also United States* v. *Brandon*, 158 F.3d 947, 953 (6th Cir. 1998) ("[F]orced medication implicates [a] Fifth Amendment liberty interest in being free from bodily intrusion").

Second, the defendant's interest in avoiding forcible administration of antipsychotic drugs is particularly weighty because (a) those drugs in many cases have quite serious side effects, and (b) they operate on the individual's thought processes, and thus implicate fundamental issues of personhood and individuality, beyond those that might be implicated by compulsory introduction of other medications (such as vaccinations or sedatives). We address the side effects of antipsychotic drugs in greater detail below (*see* pp. 20-25, *infra*), but for present purposes it bears emphasis that such drugs are "often accompanied by toxic reactions and adverse side effects, some of which are quite serious and irreversible." Bruce J. Winick, *The Right to Refuse Medical Treatment* 72 (1997); *see* Rafael A. Rivas-Vazquez et al., *Atypical Antipsychotic Medications: Pharmacological Profiles and Psychological Implications*, 31 Prof. Psychol. Res. & Prac. 628, 629-630, 633-635 (2000). The side effects of antipsychotic

drugs are well documented in the scientific literature[5] and have often been recognized by the courts.[6]

Moreover, because antipsychotic drugs operate on the functioning of the brain, their coercive use by the government implicates basic liberties of thought and conscience protected by the First and Fourteenth Amendments. *Cf. Palko*, 320 U.S. at 326-327 ("[F]reedom of thought . . . is the matrix, the indispensable condition, of nearly every other form of freedom. With rare aberrations a pervasive recognition of that truth can be traced in our history, political and legal."); *West Va. State Bd. of Educ.* v. *Barnette*, 319 U.S. 624, 642 (1943) (identifying a "sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from official control"); *Stanley* v. *Georgia*, 394 U.S. 557, 565 (1969) ("Our whole Constitutional heritage rebels at the thought of giving government the power to control men's minds."). Although this Court has not precisely identified the nature of an individual's interest in refusing to take antipsychotic drugs, as compared with refusing other forms of medication, given those drugs' powerful effects on cognition, and thus on the individual's very personhood, their forcible administration implicates the First Amendment as well as the Due Process Clauses of the Fifth and Fourteenth Amendments.

Third, antipsychotic medication may adversely affect the defendant's fair trial rights under the Fifth and Sixth Amendments. The first set of risks involves well-known side

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[5] *See, e.g.*, Rivas-Vazquez et al., *supra*, at 629-630; Philip G. Janicak et al., *Principles and Practice of Psychopharmacology* 188-217; *Drug-Induced Dysfunction in Psychiatry* 107-168 (Matcheri S. Keshavan & John S. Kennedy eds., 1992).

[6] *See, e.g.*, *Riggins*, 504 U.S. at 134; *id.* at 142-144 (Kennedy, J., concurring); *Harper*, 494 U.S. at 229-230; *Mills* v. *Rogers*, 457 U.S. 291, 293 n.1 (1982); *United States* v. *Weston*, 255 F.3d 873, 877 n.3 (D.C. Cir. 2001); *Kulas* v. *Valdez*, 159 F.3d 453, 455-456 (9th Cir. 1998), *cert. denied*, 528 U.S. 1167 (2000); *United States* v. *Brandon*, 158 F.3d 947, 954 (6th Cir. 1998).

effects associated with certain antipsychotic drugs: they can alter the individual's demeanor "in a manner that will prejudice his reactions and presentation in the courtroom," such that he will appear unsympathetic to the jury or even the judge. *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring). Some antipsychotic drugs can "flatten or deaden [the recipient's] emotional responses," *United States* v. *Weston*, 206 F.3d 9, 20 (D.C. Cir. 2000) (Tatel, J., concurring), making him look "so calm or sedated as to appear bored, cold, unfeeling, and unresponsive," *Riggins*, 504 U.S. at 143 (Kennedy, J., concurring) (quotation marks omitted). In other cases, restlessness, Parkinsonian tremors, muscle spasms, and slurred speech may adversely affect the jury's opinion of a defendant. *See id.* at 142-143 (Kennedy, J., concurring). *See generally* Siegel et al., *supra*, at 324-325, 346-347 (surveying these side effects). It is particularly important for a court to be attentive to these potential side effects, because they may be overlooked by health-care professionals—to whom they may seem of minimal significance when compared to the more dramatic symptoms of active psychosis—and yet they may have a profound effect on the jury's evaluation of the defendant. *See id.* at 330 & n.122. In addition, antipsychotic drugs may dull the defendant's cognition, thus compromising his "interaction with counsel, or his comprehension at trial." *Riggins*, 504 U.S. at 138.

2. In light of these weighty, constitutionally protected individual interests, a court should not order involuntary administration of medication to restore a defendant to competence without first exploring less intrusive, non-drug-based methods of treatment. The court should first require the government to demonstrate, by clear and convincing evidence, the absence of any non-drug therapies that would be effective in restoring competence. Moreover, "[w]here the expert testimony does not clearly eliminate the possibility that other [non-drug] approaches may be efficacious, . . . they should be attempted in an effort to determine whether medication is

truly necessary to maintain the defendant's competency." Winick, *supra*, at 322.

There is no question that antipsychotic drugs are often greatly beneficial for patients with mental disorders. Precisely because of that fact, however, certain health-care professionals have a well-documented tendency to overprescribe drugs and disregard other, less intrusive modalities of treatment that may also be beneficial. *See generally* Winick, *supra*, at 76-85.[7] There is a significant danger, therefore, that health-care professionals in a forensic setting may proceed immediately to medication without considering less intrusive alternatives that might be effective in restoring competence.[8] In fact, behavioral and psychosocial therapies can be effective in treating certain aspects of psychosis, such as aggres-

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[7] There is also a danger that clinicians may overlook a diagnosis which would suggest that the patient's disorder would be responsive to non-drug therapy. *See* Theo C. Manschreck, *Delusional Disorder and Shared Psychotic Disorder*, in 1 Benjamin J. Sadock and Virginia A. Sadock, eds., *Comprehensive Textbook of Psychiatry* 1243, 1259 (7th ed. 2000) (cautioning that the clinician "should avoid the temptation to make the diagnosis of schizophrenia and delusional disorder"—which are often thought to be resistant to non-drug therapy—"prematurely in cases where paranoid features are present, as those features occur regularly in a variety of psychiatric and medical illnesses"); *id.* at 1260 (discussing difference between delusional disorders and mood disorders with psychotic features, such as depressions in which a patient may have delusions that are congruent with his mood).

[8] One scholar has noted that "[t]reatment for incompetence to stand trial in most forensic hospitals often differs little from treatment provided for mentally ill patients who are civilly committed, even though one can argue that there should be a difference in objectives when treating these two populations." Thomas Grisso, *Five-Year Research Update (1986-1990): Evaluations for Competence to Stand Trial*, 10 Behavioral Sci. & L. 353, 364 (1992); *see also* Alex M. Siegel & Amiram Elwork, *Treating Incompetence to Stand Trial*, 14 L. & Human Behavior 57, 58 (1990) (57% of forensic directors responding to a survey reported that they do not treat patients who are adjudicated incompetent any differently than other patients).

sive behavior.[9] Although such therapies are often not adequate by themselves to treat acute psychotic disorders, they may be particularly effective even for psychosis when employed along with antipsychotic drugs. *See generally* Glen O. Gabbard, *Combined Psychotherapy and Pharmacotherapy*, in 2 Benjamin J. Sadock & Virginia A. Sadock, eds., *Comprehensive Textbook of Psychiatry* 2226-2227 (7th ed. 2000). In a combined approach, moreover, lower drug doses can often be used and the course of drug therapy can often be shortened. *See* Winick, *supra*, at 322; Rivas-Vazquez et al., *supra*, at 637.

Consideration of non-drug therapies is particularly important where, as here, the specific therapeutic goal is helping an individual develop or recover functional abilities, such as assisting his attorney during a criminal trial. Trial incompetence and mental disability are not the same thing, although they are related and may overlap. *See* Siegel & Elwork, *supra*, at 58. For some individuals, the presence of psychosis does not necessarily mean the absence of the necessary understanding of the fundamentals of a criminal trial. *See* J. Robert Noonan, *Competency to Stand Trial and the Paranoid Spectrum*, 17 Am. J. Forensic Psych. 5 , 17 (1999); Robert A. Nicholson & Karen E. Kugler, *Competent and Incompetent Criminal Defendants: A Quantitative Review of*

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[9] *See* V. Lehtinen et al., *Two-Year Outcome in First-Episode Psychosis Treated According to an Integrated Model: Is Immediate Neuroleptisation Always Needed?*, 15 European Psychiatry 312, 318 (2000) (reporting study in which psychotic patients who were treated with intensive psychosocial interventions combined with no or minimal use of medications had results at least as good as those whose treatment regime included the usual doses of medications); Grisso, *supra*, at 365 (noting that one study had yielded the finding that "incompetent defendants who refused medication had a higher rate of restoration of competence" than those who had accepted antipsychotic medication); *see also* Shirley M. Glynn et al., *Compliance With Less Restrictive Aggression-Control Procedures*, 40 Hosp. & Comm. Psychiatry 82 (1989) (study demonstrated usefulness of non-restraint-based "time out" procedures to curb aggression in psychotic patients).

Comparative Research, 109 Psychol. Bull. 355, 356 (1991). Conversely, alleviating psychosis in individuals who lack those functional abilities does not necessarily restore them. Indeed, antipsychotic drugs are not designed to *develop* abilities and skills at all; rather, they are intended to suppress symptoms of certain mental disorders. Thus, determining the appropriate treatment (if any) for attempting to restore a defendant's competence to stand trial must take account of treatments designed specifically to address trial incompetence. It is here that psychological approaches, including psychosocial and psychoeducational therapies, may be most useful. Because these kinds of treatment can be designed specifically to address trial incompetence, they may be able to achieve targeted results better than antipsychotic medication alone.[10]

For individuals with some diagnoses, however—including delusional disorder—particular features of the disorder may present considerable obstacles to the effectiveness of non-drug therapy. An individual (such as Dr. Sell) with delusional disorder, persecutory type who is committed to a forensic hospital may be inelined to conclude that his therapist is part of a conspiracy against him. Treatment involving only non-drug psychotherapy may not be capable of shaking this belief, and thus may be unlikely to assist him in gaining a realistic understanding of the trial process and the role of his attorney and the judge, prosecutor, and jury—especially if the individual already is convinced that actors in the judicial process are participating in a conspiracy against him.[11] In

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[10] *See* Kirk Heilbrun et al., *The Debate on Treating Individuals Incompetent for Execution*, 149 Am. J. Psychiatry 596, 602 (1992) ("The connection between [psychosocial rehabilitation] and competency-relevant behavior seems potentially strong."). The scientific literature includes discussions of innovative and evidently successful psychosocial and psychoeducational therapies for defendants found incompetent to stand trial. *See* Grisso, *supra*, at 364; Siegel & Elwork, *supra*, at 60.

[11] Because delusional disorders are uncommon, the effectiveness of cognitive and behavioral therapies for those disorders has thus far been

some cases, therefore, a trial court may conclude, based on the professional judgment of health-care professionals who have examined an incompetent defendant, that non-drug therapy would not be effective for that person. If the court is persuaded to that effect, then the government and the individual should not be compelled to go through a pointless exercise.

B. The Trial Court Must Also Determine That The Proposed Medication Would Have A Substantial Likelihood Of Success In Restoring The Defendant To Competence, And That Its Effectiveness Clearly Outweighs The Risk From Side Effects

Even if a trial court determines that non-drug therapy would not restore a defendant to competence, it does not necessarily follow that the court would be justified in ordering administration of antipsychotic drugs. A willing patient and her therapist might well agree to try a particular medication even if its likelihood of success is far from certain and even if the side effects might be serious, and then might shift to a different medication if the first one is not effective or yields unacceptable side effects. But in the case of an individual who has competently refused medical treatment, an open-ended trial-and-error approach is inappropriate. To justify the serious intrusion onto personal autonomy that accompanies coercive administration of antipsychotic drugs, greater

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little studied. *See* Manschreck, *supra*, at 1262. Although such therapies have been described as "promising," *ibid.*, the currently prevailing view is that persons with delusional disorder tend to be "refractory to attempts to reduce their delusional thinking," *id.* at 1263. *See* Noonan, *supra*, at 12 (persons with delusional disorder are "typically not responsive to persuasion or offers of treatment, . . . [and] construe offers to medicate as yet another facet of the devious conspiracy to deprive one of his rights and do him in"); S.P. Garcelan et al., *Effectiveness of Individual Cognitive-Behavioural Therapy Applied to Psychotic Symptoms*, 4 Psychology in Spain 3, 10 (2000) (concluding that cognitive and behavioral therapy alone is unlikely to be successful for persons with delusional disorders).

assurance is necessary about any particular medication that the government proposes to be use, and serious risk must be avoided.

Before ordering a medication to be forcibly administered, a trial court must conclude that there is a substantial likelihood that the particular medication or medications to be used will be effective at restoring the individual to competence, and that the medication's benefits clearly outweigh its adverse side effects, including the possible effects on the individual's fair trial rights. *See Riggins*, 504 U.S. at 135 (finding forcible administration of antipsychotic drugs "impermissible absent a . . . determination of medical appropriateness"). There will likely be many cases (particularly those involving well-studied disorders in which the effectiveness of medication has been well documented) in which a trial court can conclude that antipsychotic medication is medically appropriate. But there may well be others (possibly including cases like this one, involving a defendant diagnosed with delusional disorder) in which the court cannot conclude that any medication has been shown with sufficient assurance to be effective with respect to a particular defendant to justify the intrusion, or that the anticipated side effects are too serious—either as an absolute matter or when compared to the anticipated benefits—to justify forcible administration. In such a situation, the court should decline to order administration of drugs, even if no non-drug therapy would likely be effective. In the case of a nondangerous individual who has not been convicted of any crime, the personal interest in autonomy is too weighty to justify intrusive administration of antipsychotic medications with speculative benefits or grave side effects.

1. Ascertaining Whether Medication Would Be Effective

a. Antipsychotic drugs are often effective in alleviating the psychotic symptoms of mental disorders. *See* Philip Janicak et al., *Principles and Practice of Psychopharmaco-*

therapy 110-133 (2d ed. 1997). Nevertheless, a substantial minority of patients do not benefit from such drugs. Winick, *supra*, at 70. For example, not all persons with mental impairments affecting competence have conditions that will respond to such drugs. For some persons, the point is obvious: no one would expect a defendant who is mentally retarded, for example, to attain competence because he has received antipsychotics.

The point is true as well for individuals with psychotic disorders, because different psychotic disorders respond differently to medication. Many judges, for example, may be generally aware of paranoid schizophrenia and may have the impression that it responds favorably to antipsychotic drugs. But paranoid schizophrenia is only one of several distinct disorders that have a passing resemblance to one another. *See* Noonan, *supra*, at 7; American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 299-300, 313-314, 323-324, 327 (4th ed. text rev. 2000) ("DSM-IV-TR").

Dr. Sell, for example, has been diagnosed with delusional disorder, persecutory type. Pet. App. 3. This disorder is uncommon, and has paranoid features distinct from those of paranoid schizophrenia.[12] Individuals with paranoid schizophrenia suffer from auditory hallucinations and bizarre delusions that are "unable to be understood from the perspective of normal human experience." Noonan, *supra*, at 7; *see also id.* at 8-9; DSM-IV-TR, *supra*, at 313-314. By contrast, although persons with delusional disorder occasionally suffer from "simple hallucinations," that is not the principal feature of the illness. *See* Theo C. Manschreck, *Delusional Disorder and Shared Psychotic Disorder*, in 1 Benjamin J. Sadock and

[12] One source states that delusional disorder has a prevalence of 0.03%. Schizophrenia, by contrast, has a lifetime prevalence of one percent. *See* Rhoda K. Hahn et al., *Current Clinical Strategies: Psychiatry* 16, 21 (2003-2004 ed.), *available at* http://www.medical-library.org/library/secure/Psychiatry.pdf.

Virginia A. Sadock, eds., *Comprehensive Textbook of Psychiatry* 1254 (7th ed. 2000). Rather, persons with delusional disorder, persecutory type, usually entertain deep-seated convictions that they are the subject of "vast, surreptitious plot[s]" to do them harm. Noonan, *supra*, at 11; *see also* Manschreck, *supra*, at 1243, 1246-1247, 1254-1255; DSM-IV-TR, *supra*, at 325. Moreover, unlike schizophrenics, persons with delusional disorder usually do *not* manifest otherwise disturbed thought processes. Indeed, they are often superficially well functioning, and can maintain employment and a family life. *Id.* at 324; Noonan, *supra*, at 11; Manschreck, *supra*, at 1254.[13]

At present, there is no consensus among researchers that delusional disorder, persecutory type will respond favorably to antipsychotic drugs, in part because of the lack of controlled studies.[14] If an individual with delusional disorder

[13] Although there is increasing awareness of the distinctiveness of delusional disorders, "clinicians are relatively ill-informed about delusional disorders and may have only seen an occasional example." Manschreck, *supra*, at 1243; *see id.* at 1244 (noting that "[m]any clinicians remember being taught that [delusional disorder] is so rare that most would not see a single such patient during an entire career"); *id.* at 1250 (stressing need for increased understanding of delusional disorder as distinct condition from schizophrenia).

[14] *See* Alan A. Felthous et al., *Are Persecutory Delusions Amenable To Treatment?*, 29 J. Am. Acad. Psych. L. 461, 461, 465 (2001) (noting "common assumption that pure persecutory delusions are hopelessly resistant to treatment," observing that "[t]here have been no controlled studies of specific agents in the treatment of delusional disorders," but concluding that "what little exists in the way of studies yields results that are not entirely hopeless"); Hernan Silva et al., *Effects of Pimozide on the Psychopathology of Delusional Disorder*, 22 Prog. Neuro-Psychopharmacol. & Biol. Psychiatry 331 (1998) (concluding that pimozide is ineffective in treating delusional disorder); Hahn et al., *supra*, at 22 (stating that delusional disorders are "often refractory to antipsychotic medication"); *see also* Manschreck, *supra*, at 1262 ("Because controlled studies are limited and the disorder is uncommon, the results required to support [treatment with antipsychotic medication] empirically have been only partially obtained.").

sought treatment voluntarily, a therapist might be justified in trying a variety of medications that have been shown to be effective with other psychotic conditions, based on the "natural presumption" (Manschreck, *supra*, at 1263) that those medications would be effective for other psychoses as well. But given the important autonomy interests at stake in the case of an individual who has competently refused antipsychotic drugs, a court would not be justified in indulging such a presumption without greater evidence that the individual's specific condition will respond to the particular proposed medication.

b. A second difficulty with antipsychotic drugs is that they may do little to address cognitive and social impairments that are so-called "negative" symptoms of some psychotic disorders, such as loss of motivation, poverty of speech, and attention deficit.[15] *See* David G. Cunningham Owens, *Adverse Effects of Antipsychotic Agents: Do Newer Agents Offer Advantages?*, 51 Drugs 895, 899 (1996) (noting a "glaring lack of professional consensus on the point" and stating that "it is hard to be sanguine" about the usefulness of medications for negative symptoms); David L. Penn et al., *Research Update on the Psychosocial Treatment of Schizophrenia*, 153 Am. J. Psychiatry 607, 607 (1996) ("[A]lthough pharmacotherapy is effective for treating acute symptoms . . . it does not alleviate residual cognitive and social deficits . . . ."). These "negative" symptoms, however, may significantly impair a defendant's competence to stand trial, and if the antipsychotic medication that the government proposes to administer cannot address them, then the usefulness of the medication may be doubtful. *See* Stephen G. Noffsinger, *Restoration to Competency Practice Guidelines*, 45 Int'l J. Offender Therapy & Comparative Criminology 356, 357 (2001) (noting that "[p]ersons with schizophrenia may have

[15] Symptoms of psychotic disorders are often categorized as "positive" or "negative." Positive symptoms include hallucinations and delusions. *See* DSM-IV-TR, *supra*, at 299-300.

cognitive impairment accompanying their psychotic symptoms, which may impair the educational component of competency restoration"). Thus, a trial court should pay careful attention to the presence of such negative symptoms and should examine whether there is a substantial likelihood that those symptoms, too, will be addressed. In some cases, the court may conclude that a combined approach of psychotherapy and medication (possibly with lower dosage) would effectively address the totality of symptoms, including negative symptoms, that impair a defendant's competence to stand trial. *See* Penn, *supra*; pp. 12-13, *supra*.

c. In light of the serious intrusion involved in compulsory administration of antipsychotic medication, more should be required than merely a showing that no *less* intrusive approach would be effective. In addition, the government should be required to demonstrate that a particular medication is substantially likely to be effective. If the government cannot make that showing, then administration of drugs should not be ordered.

It is possible that in some cases, a trial court could not confidently conclude that an individual would respond to either drug or non-drug therapy. Conceivably, in those cases, the defendants could not be brought to trial. Fortunately, there is reason to believe that such cases are uncommon. Studies have concluded that the vast majority of incompetent defendants who are involuntarily committed for treatment are successfully restored to competence.[16] Of those who cannot

[16] *See* Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 Bull. Am. Acad. Psychiatry L. 529, 541 (1993) (more than 87% restored to competence); Brian Ladds & Antonio Convit, *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Review of Empirical Studies*, 22 Bull. Am. Acad. Psychiatry L. 519, 530 (1994); Robert A. Nicholson et al., *Predicting Treatment Outcome for Incompetent Defendants*, 22 Bull. Am. Acad. Psychiatry L. 367, 368, 371 (1994); Robert A. Nicholson & John L. McNulty, *Outcome*

be restored to competence, a significant number may well present a danger to themselves or others and thus would be proper subjects for civil commitment. *Cf. Riggins*, 504 U.S. at 145 (Kennedy, J., concurring).

2. Assessing The Side Effects Of Antipsychotic Drugs

Antipsychotic drugs may be divided into two general categories: older "conventional" drugs, and the more recently developed "atypical" drugs.[17] Although both classes of drugs are often effective in treating many psychotic disorders, they both also carry risks of a range of side effects. Common side effects of conventional antipsychotic drugs include "extrapyramidal" reactions, a family of disorders including Parkinsonism, akathisia, dystonia, and (most serious of all) tardive dyskinesia.[18] Extrapyramidal reactions occur in at

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of Hospitalization for Defendants Found Incompetent to Stand Trial, 10 Behav. Sci. & L. 371, 376, 380 (1992).

[17] Conventional antipsychotic drugs include, among others, haloperidol (Haldol), thiothixene (Navane), chlorpromazine (Thorazine), and thioridazine (Mellaril). Atypical drugs include clozapine (Clozaril), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), and ziprasidone (Geodon). *See Physician's Desk Reference* (54th ed. 2000), at 2153-57 (Haldol), 2356-58 (Navane), 3050-52 (Thorazine), 1973-74 (thioridazine), 2008-2013 (Clozaril), 1453-57 (Risperdal), 1649-53 (Zyprexa), 562-66 (Seroquel).

[18] *See* Thomas R.E. Barnes & J. Guy Edwards, *The Side-Effects of Antipsychotic Drugs. I. CNS and Neuromuscular Effects*, in *Antipsychotic Drugs and Their Side-Effects* 213, 217 (1993). Parkinsonism resembles the symptoms of Parkinson's disease, and consists of muscular rigidity, resting tremors, motor retardation, a mask-like face, and pill-rolling hand movements. *Id.* at 214. Akathisia is a feeling of restlessness and a need to be in constant motion, causing the patient to pace and tap his foot incessantly. *Id.* at 223. Dystonia involves severe spasms of the head and neck muscles often accompanied by facial grimacing, involuntary spasms of the tongue and mouth, oculogyric spasms (which involve a brief, fixed stare, followed by the eyes rolling upward for minutes at a time), bizarre posture and gait, and violent movement of the arms. *Id.* at 219. Tardive dyskinesia is a "particularly pernicious" extrapyramidal reaction characterized by "involuntary, rapid, and jerky movements of facial and oral

least 50% to 75% of patients treated with conventional antipsychotic drugs; some estimates are as high as 90%. *See* Rivas-Vazquez et al., *supra*, at 630.[19] These extrapyramidal symptoms can be "subjectively quite stressful, may be incompatible with clinical improvement and with a useful life outside the hospital, and can be more unbearable than the symptoms for which the patient was originally treated." Winick, *supra*, at 73. Conventional antipsychotics frequently produce other unpleasant side effects as well, including sedation, interference with concentration, blurred vision, dry mouth and throat, constipation, urine retention, orthostatic hypotension (low blood pressure when standing), tachycardia (rapid beating of the heart), weakness, and dizziness. *See* Janicak et al., *supra*, at 201-203.[20]

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muscles, upper and lower extremities, and the trunk." Rivas-Vazquez, *supra*, at 630; *see* Barnes & Edwards, *supra*, at 228-229. As a "tardive" condition, it tends to occur after prolonged administration of an antipsychotic drug, and may not even become evident until after the drug treatment has stopped. *See* Paul S. Appelbaum, *Almost a Revolution* 116 (1994); James B. Lohr, *Tardive Dyskinesia*, in *Drug-Induced Dysfunction in Psychiatry* 131 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). Once the condition develops, it is "potentially irreversible," Rivas-Vazquez, *supra*, at 630, and in any event "may persist long after discontinuation of the antipsychotics" that caused it. *See* Lohr, *supra*, at 131.

[19] This Court has observed that "the proportion of patients treated with [conventional] antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%." *Harper*, 494 U.S. at 230. The incidence of tardive dyskinesia in older patients is much higher. *See generally* J.M. Kane, *Tardive Dyskinesia: Epidemiology and Clinical Presentation*, in *Psychopharmacology: The 4th Generation of Progress* 1485-1495 (F.E. Bloom & D.J. Kupfer eds., 1995).

[20] Conventional antipsychotics can also cause a potentially fatal disorder known as "neuroleptic malignant syndrome." Gerard Addonizio, *Neuroleptic Malignant Syndrome*, in *Drug-Induced Dysfunction in Psychiatry* 145, 145 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). If untreated, this relatively rare (but underdiagnosed) condition can lead to potentially fatal respiratory failure, cardiovascular collapse, and acute kidney failure. *See* Winick, *supra*, at 74 & n.72.

The newer, "atypical" antipsychotics, which have been determined to be effective in treating some psychotic disorders, are reported to have a more favorable side effect profile than the older conventional drugs. *See* Rivas-Vazquez et al., *supra*, at 628; Alan A. Felthous et al., *Are Persecutory Delusions Amenable To Treatment?*, 29 J. Am. Acad. Psychiatry L. 461, 463 (2001).[21] Each of these drugs, however, can also cause potentially serious side effects. Clozapine, described as "the 'gold standard' for atypical agents," Rivas-Vazquez et al., *supra*, at 634, presents a risk of agranulocytosis, a potentially fatal disappearance of white blood cells, as well as numerous other disabling side effects. *See* Janicak et al., *supra*, at 206-207.[22] Risperidone and olanzapine both carry a risk of extrapyramidal effects, particularly when used in elevated dosages, *id.* at 192-194, and quetiapine can cause cataracts. *See* Rivas-Vazquez, *supra*, at 634-635. Ziprasidone, an atypical drug recently approved by the Food and Drug Administration (FDA) for the treatment of schizophrenia, has a generally favorable side effect profile, but it has been

[21] It remains unclear, however, whether the newer drugs are more effective than the older, conventional agents in treating symptoms of psychosis. One recent study has concluded that aytpical drugs, as a class, produce no greater benefits in treating psychotic disorders than conventional drugs and also have no greater benefits in overall tolerability, although they do cause fewer extrapyramidal side effects. *See* John Geddes et al., *Atypical Antipsychotics in the Treatment of Schizophrenia: Systematic Overview and Meta-Regression Analysis*, 321 British Med. J. 1371, 1371 (2000). Moreover, that study suggests that the reported more favorable side effect profile of atypical drugs may actually result from the use of higher than recommended doses of conventional drugs in some clinical trials. *See id.* at 1374; Cunningham Owens, *supra*, at 902 (same).

[22] Evidence suggests that agranulocytosis occurs in 2% of patients receiving clozapine. *See* Robert M. Wettstein, *Legal Aspects of Prescribing*, in *Drug-Induced Dysfunction in Psychiatry* 9, 16 (Matcheri S. Keshavan & John S. Kennedy eds., 1992). It is possible to monitor patients for this syndrome and to discontinue administration of the drug before the condition becomes too grave, but such monitoring is a demanding process, requiring weekly or even twice weekly blood tests for the initial six months of treatment. *See* Janicak et al., *supra*, at 206.

linked to a potentially serious heart-rhythm irregularity, and the manufacturer has recommended against its use by patients with cardiac arrhythmia.[23] Atypical agents can also cause other side effects such as sedation, seizures, hypotension, and weight gain. Rivas-Vazquez, *supra*, at 633-635. Moreover, because atypical antipsychotic drugs have been in widespread use for only a short time, it is possible that they may also cause some late-onset side effects that have not yet been reliably identified, but that may appear in the future.

Until very recently (and when this case was decided in the lower courts), atypical drugs had been approved only for oral administration, and only conventional drugs could be administered in injectable form.[24] As a practical matter, therefore, when patients have been unwilling to accept antipsychotic medication, the only alternative has been to administer conventional drugs, with their more serious side effects, by injection. Many patients who have experience with the mental-health system and who have taken conventional antipsychotic drugs have found the side effects of those drugs to be unacceptable. Indeed, side effects constitute a principal reason why many patients stop taking antipsychotic drugs. *See* Winick, *supra*, at 73 n.67; Rivas-Vazquez et al., *supra*, at

[23] *See* Alexander H. Glassman and J. Thomas Bigger, Jr., *Antipsychotic Drugs: Prolonged QTc Interval, Torsade de Pointes, and Sudden Death*, 158 Am. J. Psychiatry 1774, 1778 (2001) (observing that "[a]lthough it is reassuring that ziprasidone was not associated with cardiac events during premarketing trials, that is not sufficient to guarantee that uncommon but life-threatening arrhythmias will not occur once the drug is in widespread use"); FDA, *Medwatch: The FDA Safety Information and Adverse Event Reporting System, 2002 Safety Alert—Geodon (ziprasidone HCl), available at* www.fda.gov / medwatch / SAFETY / 2002 / gedon.htm; Pfizer, Inc., *Geodon, available at* www.pfizer.com /download/geodon.pdf. The potential for cardiac complications from ziprasidone are likely to be of particular concern for somewhat older persons, such as Dr. Sell.

[24] *See* Paul A. Nidich & Jacqueline Collins, *Involuntary Administration of Psychotropic Medication: A Federal Court Update*, 11 No. 4 Health Law. 12, 13 n.21 (1999); *Weston*, 255 F.3d at 886 n.7.

630. In this case, for example, Dr. Sell explained his resistance to medication by stating that he had previously taken Haldol but had found the side effects to be intolerable. Pet. C.A. Br. 5; *see also* Felthous et al., *supra*, at 463 (noting that "paranoid patients are usually very sensitive to all side effects of drugs") (citation and internal quotation marks omitted).

In June 2002, the FDA approved the atypical drug ziprasidone for intramuscular injection. *See* FDA, Center for Drug Evaluation and Research, *Drug Approvals for June 2002*, *available at* http://www.fda.gov/cder/da/da0602.htm. Ziprasidone has been reported to have a much more favorable side effect profile than the conventional drugs. Regulatory approval of ziprasidone and (in the future) other atypical drugs in injectable form may significantly alter the calculus undertaken by a trial court when it decides whether to order administration of antipsychotic drugs. Although any coercive introduction of antipsychotic drugs constitutes a serious intrusion of the individual's autonomy, that intrusion may be justified when no non-drug therapy would be effective, where the drug clearly would be effective, and where the side effects are likely to be moderate. At the same time, the regulatory approval of atypical drugs in injectable form should mean that, in the future, when the government seeks to administer antipsychotic drugs to restore a defendant to competency, it should not resort to conventional drugs in the first instance but rather should propose to use atypical drugs instead, whenever there is a substantial possibility that those drugs would be effective.[25]

On the other hand, it must be recognized that atypical drugs are not panaceas. Because those drugs are new, the side effects of their long-term use is not yet known. More-

[25] If an aytpical agent that is likely to be effective is not yet available in injectable form, the government should explore administering the drug in a liquefied form, such as an elixir, rather than resorting to conventional drugs.

over, all the atypical drugs have limitations, including ziprasidone (*see* pp. 21-22, *supra*). Finally, while many antipsychotic drugs, including ziprasidone, have been well studied and have been determined by the FDA to be effective for treatment of *schizophrenia*, their effectiveness for delusional disorder is unproven. *See* pp. 16-18, *supra*. Thus, while a court might be justified in ordering injection of ziprasidone to restore the competency of a person with schizophrenia, it is much more doubtful that such coercive treatment would be justified for someone like Dr. Sell.

C. The Trial Court Should Also Consider The Effect Of Antipsychotic Drugs On The Defendant's Fifth And Sixth Amendment Rights To A Fair Trial

The coercive administration of antipsychotic drugs may compromise a defendant's Fifth and Sixth Amendment rights to a fair trial. *See Riggins*, 504 U.S. at 136-138. There are at least three different ways in which these medications may impair a defendant's fair trial rights. First, antipsychotic drugs can appear to "flatten or deaden [the recipient's] emotional responses," *Weston*, 206 F.3d at 20 (Tatel, J., concurring), making the defendant look "so calm or sedated as to appear bored, cold, unfeeling, and unresponsive." *Riggins*, 504 U.S. at 143 (Kennedy, J., concurring). Such alterations in the defendant's demeanor—whether he is testifying on his own behalf or simply sitting next to counsel—can cause "serious prejudice . . . if [the] medication inhibits the defendant's capacity to react and respond to the proceedings and to demonstrate remorse or compassion." *Id.* at 143-144 (Kennedy, J., concurring). Second, the well documented side effects of restlessness, Parkinsonian tremors, muscle spasms, and slurred speech can adversely affect the jury's opinion of a defendant. *See id.* at 142-143 (Kennedy, J., concurring). Third, antipsychotic drugs may undermine the defendant's ability to participate effectively in his own defense by dulling his cognition, and thus compromising his "interaction with

counsel, or his comprehension at trial." *Id.* at 138. Indeed, the Court in *Riggins* found "a strong possibility that [the defendant's] defense was impaired" in that manner. *Id.* at 137.[26]

A court should be particularly attentive to these potential side effects, because they may not appear so significant to a health-care professional as they would appear to a juror, especially if the therapist does not usually work in a forensic health-care field. Compared to the dramatic symptoms of

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[26] In addition, in some cases, the intended effect of administering antipsychotic drugs—namely, suppressing psychotic symptoms—may compromise the defendant's Sixth Amendment right to raise certain defenses at trial. For example, rendering a previously delusional individual competent may impair her ability to mount an effective insanity defense by removing the best evidence of that insanity: the physical manifestations of her own mental state. To be sure, a defendant rendered competent by the administration of drugs might still attempt to mount an insanity defense—by, for example, relying on the testimony of therapists who had treated her before she was medicated, testifying herself about her unmedicated mental state, or introducing a videotape recording of herself prior to the administration of the medication. None of those alternatives, however, is likely to be as effective as the defendant's testimony and courtroom presence in her unmedicated state. Empirical research shows that jurors who think the accused is displaying psychotic symptoms at the time of trial are significantly more likely to return a verdict of not criminally responsible on account of mental disorder than are those who think the accused is symptom-free during the trial. *See* Karen E. Whittemore & James R.P. Ogloff, *Factors That Influence Jury Decision Making: Disposition Instructions and Mental States at the Time of the Trial*, 19 L. & Hum. Behav. 283, 292 (1995); *see also Weston*, 206 F.3d at 21-22 (Tatel, J., concurring).

As with the risk of unfair trial prejudice caused by the side effects of antipsychotic drugs, concern about a defendant's ability to mount an effective defense of insanity or impairment is best addressed at the time of trial. *See* p. 27, *infra*. The trial court will then be able to consider the defenses the defendant proposes to mount, and, to the extent any of them involve claims about the defendant's mental state at the time of the offense, assess whether there are alternative ways for the defendant effectively to mount the defense, including other evidence of her earlier mental state. *Cf. Riggins*, 504 U.S. at 145 (Kennedy, J., concurring).

full-blown schizophrenia or the devastating consequences of tardive dyskinesia, a flat affect or an appearance of restlessness may seem inconsequential. But to a juror who sees only the medicated defendant, an appearance of boredom or restlessness may suggest that the defendant cares little about the judicial proceedings. Thus, the trial court should ensure that the defendant be monitored for such changes in his demeanor.

On the other hand, it may be difficult for the court adequately to evaluate the significance of these side effects for the defendant's trial rights until the drugs have been administered and their effects in the given case are understood. The court would then be able to determine the precise effects of the medication and the likely impact of those effects on the defendant's fair trial rights. *See United States* v. *Weston*, 255 F.3d 873, 886 n.8 (D.C. Cir. 2001). If, at the time of trial, the court determines that the antipsychotic drugs have caused side effects that will impair the defendant's right to a fair trial, the court should conclude that the defendant cannot be tried while medicated.[27]

CONCLUSION

For the foregoing reasons, antipsychotic drugs should not be forcibly administered to a criminal defendant for the purpose of rendering him competent to stand trial unless the

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[27] Some courts have suggested that the trial court should instruct the jury about the defendant's medication and its effects, and admonish the jury not to draw adverse inferences about the defendant based on her appearance and demeanor. *See Weston*, 255 F.3d at 886. Such an approach, however, is likely to be appropriate only in the rare case. First, jury instructions of that kind may seriously prejudice the defendant by informing the jury that the defendant is mentally ill, a fact of which the jury might not otherwise be aware. Second, given the great significance that jurors customarily pay to a defendant's demeanor—which usually forms a fundamental part of their evaluation of her credibility—it may be doubtful that such a cautionary instruction would be effective. *See Riggins*, 504 U.S. at 143-144 (Kennedy, J., concurring); J. Alexander Tanford, *The Law and Psychology of Jury Instructions*, 69 Neb. L. Rev. 71, 95 (1990).

government proves to the trial court that less intrusive non-drug alternatives would be ineffective in accomplishing the same objective; that there is a substantial likelihood that the particular drug proposed to be used will render the defendant competent for trial; and that the benefits from that medication clearly outweigh its side effects. In addition, once antipsychotic drugs are administered and the defendant is brought to trial, the government should be required to show that the drugs will not materially impair the defendant's ability to present an effective defense.

Respectfully submitted.

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